1833(a)(1)(A) of the Act, and that would not otherwise meet the conditions specified in paragraph (b)(1) of this section, may receive reimbursement on a reasonable cost basis as an HCPP, provided it files an agreement with CMS as required by §417.801.

(c) *Payment of reasonable cost.* (1) Except as otherwise provided in this subpart, CMS pays an HCPP on the basis of the reasonable cost it incurs, as specified in subpart O of this part, for the covered Part B services furnished to its Medicare enrollees.

(2) *Payment for Part B services: Basic rules*—(i) *Cost basis payment.* Except as provided in paragraph (d) of this section, CMS pays an HCPP on the basis of the reasonable costs it incurs, as specified in subpart O of this part, for the covered Part B services furnished to its Medicare enrollees.

(ii) *Deductions.* In determining the amount due an HCPP for covered Part B services furnished to its Medicare enrollees, CMS deducts, from the reasonable cost actually incurred by the HCPP, the following:

(A) The actuarial value of the Part B deductible.

(B) An amount equal to 20 percent of the cost incurred for any service that is subject to the Medicare coinsurance.

(d) *Covered services not reimbursed to an HCPP.* (1) Services reimbursed under Part A are not reimbursable to an HCPP. CMS makes payment for these services directly to the hospital, or other provider of services, on a reasonable cost basis through the provider's Medicare fiscal intermediary (for more details, see parts 412 and 413 of this chapter).

(2) Covered Part B services furnished by a provider of services to an HCPP's Medicare enrollees are not payable to the HCPP. CMS makes payment for these services to the provider on behalf of the Medicare enrollee through the provider's Medicare fiscal intermediary. This requirement does not affect Medicare payment to the HCPP for physicians' services furnished to its Medicare enrollees for which the physicians are compensated by the HCPP.

(e) *Payment for services to nonenrollees.* CMS makes payment to an HCPP for covered Part B services furnished by the HCPP to a Medicare beneficiary who is not enrolled in the HCPP if the beneficiary assigns his rights to payment in accordance with §424.55 of this chapter. Payment is made on a reasonable charge basis through the HCPP's Medicare carrier.

[50 FR 1346, Jan. 10, 1985, as amended at 51 FR 34833, Sept. 30, 1986; 53 FR 6648, Mar. 2, 1988; 57 FR 7135, Feb. 28, 1992; 58 FR 38081, July 15, 1993; 60 FR 34888, July 5, 1995; 63 FR 35067, June 26, 1998; 63 FR 52611, Oct. 1, 1998]

§417.801 Agreements between CMS and health care prepayment plans.

(a) *General requirement.* (1) In order to participate and receive payment under the Medicare program as an HCPP as defined in §417.800, an organization must enter into a written agreement with CMS.

(2) An existing group practice prepayment plan (GPPP) that continues as an HCPP under this subpart U must have entered into a written agreement with CMS within 60 days of January 31, 1983.

(b) *Terms.* The agreement must provide that the HCPP agrees to—

(1) Maintain compliance with the requirements for participation and reimbursement on a reasonable cost basis of HCPPs as specified in §417.800;

(2) Not charge the Medicare enrollee or any other person for items or services for which that enrollee is entitled to have payment made under the provisions of this part, except for any deductible or coinsurance amounts for which the enrollee is liable;

(3) Refund, as promptly as possible, any money incorrectly collected as charges or premiums, or in any other way from Medicare enrollees in the HCPP in accordance with the requirements specified in §417.456;

(4) Not impose any limitations on the acceptance of Medicare enrollees or beneficiaries for care and treatment that it does not impose on all other individuals;

(5) Meet the advance directives requirements specified in §417.436(d) of this part;

(6) Establish administrative review procedures in accordance with §§417.830 through 417.840 for Medicare enrollees who are dissatisfied with denied services or claims; and

(7) Consider any additional requirements that CMS finds necessary or desirable for efficient and effective program administration.

(c) *Duration of agreement.* Except for the term of the initial agreement, the agreement is for a term of one year and may be renewed annually by mutual consent. The term of the initial agreement is set by CMS.

(d) *Termination or nonrenewal of agreement by CMS.* (1) CMS may terminate or not renew an agreement if it determines that—

(i) The HCPP no longer meets the requirements for participation and reimbursement as an HCPP as specified in § 417.800;

(ii) The HCPP is not in substantial compliance with the provisions of the agreement, applicable CMS regulations, or applicable provisions of the Medicare law. This includes, but is not limited to, the following:

(A) Failure to provide for and document adequate access to providers.

(B) Failure to comply with CMS requirements concerning provision of data and maintenance of records.

(C) Failure to comply with financial requirements specified at § 417.806; or

(iii) The HCPP undergoes a change in ownership as specified in subpart M of this part.

(2) CMS will give notice of termination or nonrenewal to the HCPP at least 90 days before the effective date stated in the notice.

(e) *Termination or nonrenewal of agreement by HCPP.* (1) If an HCPP does not wish to renew its agreement at the end of the term, it must give written notice to CMS at least 90 days before the end of the term of the agreement. If an HCPP wishes to terminate its agreement before the end of the term, it must file a written notice with CMS stating the intended effective date of termination.

(2) CMS may approve the termination date proposed by the HCPP, or set a different date no later than 6 months after that date. CMS makes this decision based on a finding that termination on a specific date would not—

(i) Unduly disrupt the furnishing of services to the community serviced by the HCPP; or

(ii) Otherwise interfere with the efficient administration of the Medicare program.

[50 FR 1375, Jan. 10, 1985, as amended at 57 FR 8202, Mar. 6, 1992; 58 FR 38081, July 15, 1993; 59 FR 49843, Sept. 30, 1994; 59 FR 59943, Nov. 21, 1994; 77 FR 22166, Apr. 12, 2012]

§ 417.802 Allowable costs.

(a) *General rule.* The costs that are considered allowable for HCPP reimbursement are the same as those for reasonable cost HMOs and CMPs specified in subpart O of this part, except those in §§ 417.531, 417.532 (a)(3) and (c) through (g), 417.536 (l) and (m), 417.546, 417.548, and 417.550(b)(2).

(b) *Physicians' services and other Part B supplier services furnished under arrangements*—(1) *Principle.* The amount paid by an HCPP for physicians' services and other Part B supplier services furnished under arrangements is an allowable cost to the extent it is reasonable.

(2) *Application: Payment on other than a fee-for-service basis.* If the HCPP pays for physicians' services and other Part B supplier services on other than a fee-for-service basis—

(i) Except as specified in paragraph (b)(2)(ii) of this section, the costs incurred by the HCPP may be considered reasonable if they—

(A) Do not exceed those that a prudent and cost-conscious buyer would incur to purchase those services; and

(B) Are comparable to costs incurred for similar services furnished by similar physicians and other suppliers in the same or a similar locality.

(ii)(A) If a physician group to whom the HCPP makes payment compensates its physicians on a fee-for-service basis, the HCPP's payment to the group may not exceed the reasonable charges for those services, as defined in subpart E of part 405 of this chapter.

(B) Payment in excess of the limits specified in paragraph (b)(2)(ii)(A) of this section is allowable if the group has procedures under which members of the group accept effective incentives, such as risk-sharing, designed to avoid unnecessary or unduly costly utilization of health services. In such cases, the amount paid by the HCPP is considered reasonable if it meets the